		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040840

Facility Name: CRESTVIEW HEALTHCARE CENTER

Address: US HWY 51 N., BOX 923 (Number) CLINTON (City) 61727 (Zip Code)

County: DEWITT

Telephone Number: (217)935-3284 **Fax #** (217)935-3826

IDPA ID Number: 351947211004

Date of Initial License for Current Owners: 6/7/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cathy Simeoni **Telephone Number:** (714) 596-7713, Ext 12

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) LINDA HOLTZSCHEITER
(Title) REIMBURSEMENT MANAGER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Cathy Simeoni, Manager - Healthcare Consulting
(Firm Name & Address) Kellogg & Andelson, Accountancy Corporation, 16162 Beach Blvd, #308, Huntington Beach, CA 92647
(Telephone) (714) 596-7713 Fax # (714) 596-7721

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	103	Intermediate (ICF)	103	37,595	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	103	TOTALS	103	37,595	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	14,279	7,112	492	21,883	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,279	7,112	492	21,883	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.21%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 6/7/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/7/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	90,128	7,426	7,752	105,306		105,306	(2,312)	102,994			1
2	Food Purchase		92,094		92,094		92,094		92,094			2
3	Housekeeping	49,817	10,299	39	60,155		60,155		60,155			3
4	Laundry	35,428	7,672		43,100		43,100		43,100			4
5	Heat and Other Utilities			75,932	75,932		75,932	262	76,194			5
6	Maintenance	30,270	32,094	10,677	73,041		73,041	217	73,258			6
7	Other (specify):*											7
8	**TOTAL General Services**	205,643	149,585	94,400	449,628		449,628	(1,833)	447,795			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	675,490	16,854	8,677	701,021		701,021		701,021			10
10a	Therapy											10a
11	Activities	35,100	2,935	1,895	39,930		39,930		39,930			11
12	Social Services	12,978		2,233	15,211		15,211		15,211			12
13	Nurse Aide Training											13
14	Program Transportation			760	760		760		760			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	723,568	19,789	17,165	760,522		760,522		760,522			16
	C. General Administration											
17	Administrative	62,765			62,765		62,765		62,765			17
18	Directors Fees											18
19	Professional Services			755	755		755	2,132	2,887			19
20	Dues, Fees, Subscriptions & Promotions			6,581	6,581		6,581	63	6,644			20
21	Clerical & General Office Expenses	89,985	5,771	57,755	153,511		153,511	23,542	177,053			21
22	Employee Benefits & Payroll Taxes			201,966	201,966		201,966		201,966			22
23	Inservice Training & Education			1,072	1,072		1,072		1,072			23
24	Travel and Seminar			3,322	3,322		3,322	1,640	4,962			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			74,312	74,312		74,312	(36,645)	37,667			26
27	Other (specify):*											27
28	**TOTAL General Administration**	152,750	5,771	345,763	504,284		504,284	(9,268)	495,016			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,081,961	175,145	457,328	1,714,434		1,714,434	(11,101)	1,703,333			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER #0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			90,809	90,809		90,809	109,840	200,649			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			58,564	58,564		58,564		58,564			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* See attached 4.2							2,445	2,445			36
37	**TOTAL Ownership**			149,373	149,373		149,373	112,285	261,658			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		19	9,756	9,775		9,775		9,775			39
40	Barber and Beauty Shops			7,141	7,141		7,141	(7,141)				40
41	Coffee and Gift Shops			2,605	2,605		2,605	(2,605)				41
42	Provider Participation Fee			56,393	56,393		56,393		56,393			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		19	75,895	75,914		75,914	(9,746)	66,168			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,081,961	175,164	682,596	1,939,721		1,939,721	91,438	2,031,159			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,312)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,977)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	60,177			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 43,888		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	47,550		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 47,550		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 91,438		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CRESTVIEW HEALTHCARE CENTER

ID# **0040840**

Report Period Beginning: **1/1/01**

Ending: **12/31/01**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	SALES TAX	$ (1,439)	21	1
2	MEMORIUM/BENEVOLANCE EXPENSE	(1,038)	21	2
3	BARBER&BEAUTY SHOP	(7,141)	40	3
4	GIFT SHOP	(2,605)	41	4
5	FAS 121**	236,933	30	5
6	Depreciation Reconciliation	(127,093)	30	6
7	VENDING RECEIPTS	(559)	21	7
8	Professional Liability Insurance	(36,881)	26	8
9				9
10	**The facility re-valued their assets in 1999. We			10
11	have reported the historical costs of the assets			11
12	consistent with the prior years, and have ensured			12
13	that depreciation expense is reported on straight			13
14	line. This adjustment is necessary to reverse the			14
15	re-valuation of historical cost.			15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	60,177		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(2,312)	0	0	0	0	0	0	0	0	0	0	(2,312)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	262	0	0	0	0	0	0	0	0	0	262	5
6	Maintenance	0	217	0	0	0	0	0	0	0	0	0	217	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,312)	479	0	0	0	0	0	0	0	0	0	(1,833)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,132	0	0	0	0	0	0	0	0	0	2,132	19
20	Fees, Subscriptions & Promotions	0	63	0	0	0	0	0	0	0	0	0	63	20
21	Clerical & General Office Expenses	(17,013)	40,555	0	0	0	0	0	0	0	0	0	23,542	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,640	0	0	0	0	0	0	0	0	0	1,640	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(36,881)	236	0	0	0	0	0	0	0	0	0	(36,645)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(53,894)	44,626	0	0	0	0	0	0	0	0	0	(9,268)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(56,206)	45,105	0	0	0	0	0	0	0	0	0	(11,101)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	109,840	0	0	0	0	0	0	0	0	0	0	109,840	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	2,445	0	0	0	0	0	0	0	0	0	2,445	36
37	**TOTAL Ownership**	109,840	2,445	0	0	0	0	0	0	0	0	0	112,285	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(7,141)	0	0	0	0	0	0	0	0	0	0	(7,141)	40
41	Coffee and Gift Shops	(2,605)	0	0	0	0	0	0	0	0	0	0	(2,605)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(9,746)	0	0	0	0	0	0	0	0	0	0	(9,746)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	43,888	47,550	0	0	0	0	0	0	0	0	0	91,438	45

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Post Acute Network	100	See Attached Pg 6.1		Mariner Post Acute Network	Atlanta, GA	Bookkeeping & Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Post Acute Network	100.00%	$ 262	$ 262	1
2	V	6	Repairs and Maintenance		Mariner Post Acute Network	100.00%	217	217	2
3	V	19	Professional Services		Mariner Post Acute Network	100.00%	2,132	2,132	3
4	V	20	Fees, Subscriptions, Promotions		Mariner Post Acute Network	100.00%	63	63	4
5	V	10	Nursing and Medical Records		Mariner Post Acute Network	100.00%			5
6	V	21	Clerical and General Office Exp		Mariner Post Acute Network	100.00%	40,555	40,555	6
7	V	24	Travel and Seminar		Mariner Post Acute Network	100.00%	1,640	1,640	7
8	V	26	Insurance Premium		Mariner Post Acute Network	100.00%	236	236	8
9	V	36	Depreciation		Mariner Post Acute Network	100.00%			9
10	V	36	Taxes-Property		Mariner Post Acute Network	100.00%	10	10	10
11	V	36	Rental & Leasing		Mariner Post Acute Network	100.00%	434	434	11
12	V	36	Lease Expense		Mariner Post Acute Network	100.00%	2,001	2,001	12
13	V	36	Property Insurance		Mariner Post Acute Network	100.00%			13
14	Total			$			$ 47,550	$ * 47,550	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4	NOT APPLICABLE										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Post Acute Network
Street Address: One Ravine Dr., Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: (770) 379-8203
Fax Number: (770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Facility Costs			$ 20,767	$		$ 262	1
2	6	Repairs and Maintenance	Facility Costs			9,731			217	2
3	19	Professional Services	Facility Costs			205,127			2,132	3
4	20	Fees, Subscriptions, Promotions	Facility Costs			6,427			63	4
5	10	Nursing and Medical Records	Facility Costs			67,554				5
6	21	Clerical and General Office Exp	Facility Costs			6,582,242			40,555	6
7	24	Travel and Seminar	Facility Costs			638,416			1,640	7
8	26	Insurance Premium	Facility Costs			(129,286)			236	8
9	36	Depreciation	Facility Costs			735,846				9
10	36	Taxes-Property	Facility Costs			30,882			10	10
11	36	Rental & Leasing	Facility Costs			185,889			434	11
12	36	Lease Expense	Facility Costs			98,311			2,001	12
13	36	Property Insurance	Facility Costs			76				13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 8,451,982	$		$ 47,550	25

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HEALTH CARE CAPITAL FIN		X	REFINANCE	$38,874.00	5/10/95	$ 4,000,000	$	2/10/02	0.1072	$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$38,874.00		$ 4,000,000	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,000,000	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	50,491	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	55,775	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,284	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	53,280	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	58,564	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	55,947	8
	1997	58,769	9
	1998	55,875	10
	1999	73,167	11
	2000	60,481	12

2001 Tax Accrual = 53,280

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CRESTVIEW HEALTHCARE CENTER COUNTY DEWITT

FACILITY IDPH LICENSE NUMBER 0040840

CONTACT PERSON REGARDING THIS REPORT Cathy Simeoni, Kellogg & Andelson

TELEPHONE (714) 596-7713 FAX #: (714) 596-7721

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-27-251-001	S27 T20 R2, N 15 A SW NE	$ 67,582.94	$ 67,582.94
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 67,582.94	$ 67,582.94

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,650 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	234,000	1994	$ 33,093	1
2	FACILITY		1994	113,113	2
3	TOTALS	234,000		$ 146,206	3

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	103		1994	1974	$ 3,987,150	$ 113,919	35	$ 113,919	$	$ 862,305	4
5			1994		82,411	4,121	20	4,121		31,192	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13	FIRE ALARM SYSTEM			1996	1,798	90	20	90		465	13
14	ACQUISITION-BUILDING IMPROVEMENTS			1994	348,471	17,424	20	17,424		131,888	14
15	ROOF			1995	15,762	788	20	788		4,845	15
16	PARKING LOT			1996	2,270	114	20	114		619	16
17	ROOF REPAIR			1997	32,544	1,627	20	1,627		7,475	17
18											18
19	TILE WALLS SHOWER			1997	2,479	124	20	124		528	19
20	SHOWER VALVES			1997	2,577	129	20	129		537	20
21											21
22	LAUNDRY EQUIPMENT- PLUMBING/PVC			1998	946	39	20	39		156	22
23	PLUMBING/PLUMBING FIXTURES			1998	539	23	20	23		92	23
24	WALK-IN COOLER			1998	10,265	43	20	43		172	24
25	HEATING, VENTILATION, A/C			1998	3,850	64	20	64		256	25
26	BOILER			1998	1,100	55	20	55		220	26
27	BOILER			1998	712	36	20	36		144	27
28											28
29	RECONCILING ADJUSTMENT TO WTB 1998					96,393			(96,393)		29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LIGHT FIXTURES	1997	$ 978	$ 98	20	$ 49	$ (49)	$ 238	37
38	FIRE ALARM SYSTEM	1996	2,087	209	20	104	(105)	527	38
39	WATER INLET VALVE	1997	627	63	20	31	(32)	128	39
40	REPAIR WATER PIPES	1997	3,320	332	20	166	(166)	643	40
41	BOILER REPAIR	1997	1,100	110	20	55	(55)	183	41
42									42
43	CONVERSION PROJECT - S	1999	25,450	1,697	15	1,697		3,394	43
44	PLUMBING WORK - SEWER	1999	2,077	104	20	104		208	44
45	SOUTH WING CONVERSION	1999	26,651	1,777	15	1,777		3,258	45
46									46
47	300,000 BTU W/HEATER, SOUTH	2000	5,456	546	10	546		1,091	47
48	REPIPING - HOT WATER/INST'L PLUM	2000	5,200	520	10	520		1,040	48
49	RPLC FIRE ALARM CONTROL PANEL	2000	1,080	99	10	99		207	49
50	AMER STANDARD 10T GAS R/TOP AC UN	2000	8,800	440	10	440		1,320	50
51	CONTROL VALVES AND BACKFLOW PREV	2000	10,860	145	25	145		579	51
52	WIRE TO EMERGENCY GENERATOR	2000	6,097	76	20	76		381	52
53	WIRE TO EMERGENCY GENERATOR	2000	1,399	17	20	17		87	53
54	ELEC OUTLET, FOOD PROCESSOR	2000	686	11	10	11		80	54
55	TEST/BALANCE AIR EXCHANGE SYS	2000	1,913	16	10	16		207	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,596,655	$ 241,249		$ 144,449	$ (96,800)	$ 1,054,466	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,596,655	$ 241,249		$ 144,449	$ (96,800)	$ 1,054,466	1
2	Instl Charge, 2:Sinks	2001	413	14	20	14		14	2
3	2:Kohler Service Sinks, ServGua	2001	1,365	51	20	51		51	3
4	Engineering Fees - Lift Station	2001	203	27	25	27		176	4
5	Rprs HVAC	2001	17,450	388	15	388		388	5
6	Legal Fees - CON Application	2001	10,018	1,302	25	1,302		1,302	6
7	Engineering Fees-Sewage System	2001	6,149	799	25	799		799	7
8	Engineering Fees-Sewage System	2001	2,300	299	25	299		299	8
9	Engineering Fees-Sewage System	2001	3,173	412	25	412		412	9
10	Engineering Fees - Lift Station	2001	60	8	25	8		52	10
11	Engineering Fees - Lift Station	2001	120	15	25	15		15	11
12	Engineering Fees-Sewage System	2001	1,513	192	25	192		192	12
13	Engineering Fees-Sewage System	2001	427	54	25	54		54	13
14	Legal Fees - CON Application	2001	10,869	1,341	25	1,341		1,341	14
15	Legal Fees - CON Application	2001	2,230	275	25	275		275	15
16	Consultant Contract-CON Appl 1	2001	50,000	6,000	25	6,000		6,000	16
17	Consultant Contract-CON Appl 2	2001	50,000	6,000	25	6,000		6,000	17
18	Engineering Fees-Sewage System	2001	366	43	25	43		43	18
19	Engineering Fees-Sewage System	2001	96	11	25	11		11	19
20	Legal Fees - CON Application	2001	2,229	260	25	260		260	20
21	Legal Fees - CON Application	2001	7,770	907	25	907		906	21
22	Architect Fees - CON Application	2001	2,300	337	25	337		337	22
23	Architect Fees - CON Application	2001	3,200	469	25	469		469	23
24	Architect Fees - CON Application	2001	5,446	799	25	799		799	24
25	Architect Fees - CON Application	2001	5,036	806	25	806		806	25
26	Architect Fees - CON Application	2001	25	4	25	4		4	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,779,414	$ 262,062		$ 165,262	$ (96,800)	$ 1,075,472	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,779,414	$ 262,062		$ 165,262	$ (96,800)	$ 1,075,472	1
2	Legal Fees - CON - Filing Fees	2001	15,031	2,054	25	2,054		2,054	2
3	Legal Fees - CON - Application	2001	8,139	1,112	25	1,112		1,112	3
4	Legal Fees - CON - Review, Filing	2001	10,649	1,491	25	1,491		1,491	4
5	Legal Fees - CON - Application	2001	2,565	368	25	368		368	5
6	Legal Fees - CON - Application	2001	9,848	1,444	25	1,444		1,444	6
7	Legal Fees - CON - Application	2001	9,757	1,398	25	1,398		1,398	7
8	Engineering Fees-Sewage System	2001	465	57	25	57		57	8
9	Engineering Fees-Sewage System	2001	3,994	493	25	493		493	9
10	Arch Fee, State Mech Issue(Air)	2001	6,750	225	10	225		225	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,846,611	$ 270,705		$ 173,905	$ (96,800)	$ 1,084,115	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 274,370	$ 26,603	$ 26,603	$	10	$ 185,510	71
72	Current Year Purchases	2,119	141	141		15	141	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 276,489	$ 26,744	$ 26,744	$		$ 185,651	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,269,306	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 297,449	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 200,649	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (96,800)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,269,766	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	OVERHEAD ALLOCATION	$ 4,693	$ 234	$ 867	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 4,693	$ 234	$ 867	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 0 Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts		226	9,734	19	226	9,753	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Audiologist					22			22	13
14	TOTAL			$	226	$ 9,756	$ 19	226	$ 9,775	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER **#** 0040840 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/01 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 900	$	1
2	Cash-Patient Deposits	10,138		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	191,300		3
4	Supply Inventory (priced at)	17,142		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	182,682		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 402,162	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,131,430		13
14	Buildings, at Historical Cost	1,381,540		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	114,100		16
17	Accumulated Depreciation (book methods)	(631,138)		17
18	Deferred Charges	117,000		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,112,932	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,515,094	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 63,376	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	94,806		30
31	Accrued Taxes Payable (excluding real estate taxes)	(436)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,280		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SEE ATTACHED SCHEDULE 17.1	3,846,718		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,057,744	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	SEE ATTACHED SCHEDULE 17.1	3,705,893		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,705,893	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,763,637	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,248,543)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,515,094	$	48

***(See instructions.)**

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,475,868)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,475,868)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	215,479	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 215,479	17
	B. Transfers (Itemize):		
18	**Intercompany Transfers**	11,846	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 11,846	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (5,248,543)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,293,738	1
2	Discounts and Allowances for all Levels	(197,880)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,095,858	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	8,303	13
14	Non-Patient Meals	2,312	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	48,619	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 59,234	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine	559	28
28a	Miscellaneous Receipts	(451)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 108	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,155,200	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	449,627	31
32	Health Care	760,521	32
33	General Administration	504,286	33
	B. Capital Expense		
34	Ownership	149,373	34
	C. Ancillary Expense		
35	Special Cost Centers	19,521	35
36	Provider Participation Fee	56,393	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,939,721	40
41	**Income before Income Taxes (line 30 minus line 40)****	215,479	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 215,479	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,037	2,193	$ 55,691	$ 25.39	1
2	Assistant Director of Nursing	2,032	2,187	48,409	22.13	2
3	Registered Nurses	8,943	9,625	174,551	18.14	3
4	Licensed Practical Nurses	8,113	8,732	112,369	12.87	4
5	Nurse Aides & Orderlies	29,028	31,242	288,055	9.22	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,010	2,163	18,649	8.62	9
10	Activity Assistants	2,224	2,394	16,009	6.69	10
11	Social Service Workers	1,202	1,294	12,520	9.68	11
12	Dietician					12
13	Food Service Supervisor	1,191	1,282	14,492	11.30	13
14	Head Cook	4,763	5,126	37,956	7.40	14
15	Cook Helpers/Assistants	5,926	6,378	40,800	6.40	15
16	Dishwashers					16
17	Maintenance Workers	2,809	3,024	30,300	10.02	17
18	Housekeepers	6,657	7,165	52,244	7.29	18
19	Laundry	4,871	5,243	35,310	6.73	19
20	Administrator	1,957	2,106	56,507	26.83	20
21	Assistant Administrator					21
22	Other Administrative	1,882	2,026	36,235	17.88	22
23	Office Manager					23
24	Clerical	3,305	3,557	42,734	12.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,000	1,077	9,130	8.48	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	89,950	96,814	$ 1,081,961 *	$ 11.18	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	149	$ 5,953	1-3	35
36	Medical Director	24	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,895	11-3	44
45	Social Service Consultant	36	2,233	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	245	$ 13,681		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Terry Shores	Administrator	0	$ 62,765
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 62,765

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Fees	Legal Fees	$ 755
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 755

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,010
Unemployment Compensation Insurance	13,187
FICA Taxes	79,712
Employee Health Insurance	61,044
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	11,013
TOTAL (agree to Schedule V, line 22, col.8)	$ 201,966

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues	6,181
Home Office Allocation	63
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,644

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,789
Home Office Allocation	1,640
Seminar Expense	533
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,962

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER # 0040840 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CRESTVIEW HEALTHCARE CENTER **#** 0040840 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS HEALTH CARE ASSOC.**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **15 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line _____

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **56,393**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? **YES** Indicate the amount. $ **2,312**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.